

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048609

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318 Primary Registration District No. 1003 Registrar's No. 12082

FILED DEC 21 1962

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis, Missouri TOWN Masonic Home of Missouri		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Masonic Home of Missouri		d. STREET ADDRESS (If outside, give location) 5351 Delmar Boulevard Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Emma Middle Margaret Last Mueller		Month 12 Day 15 Year 62	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-31-1890
9. AGE (last birthday) 72		IF UNDER 1 YEAR Months 3 Days 15 IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Henry Frank		13b. MOTHER'S MAIDEN NAME Ida Zahn	
14. NAME OF HUSBAND OR WIFE Deceased-George Mueller		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Masonic Home of Mo.-5351 Delmar Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 331x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 48 hrs unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 11-1-58 to 12-15-62 and last saw her/him alive on 12-14-62 Death occurred at 2:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Harold E. Walters M.D.	
22b. ADDRESS 3720 Washington St. Louis		22c. DATE SIGNED 12-15-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 17, 1962	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR: ADDRESS Kriegshauser 4228 S. Kingshighway Blvd.		25. DATE RECD. BY LOCAL REG. DEC 17 1962	
26. REGISTRAR'S SIGNATURE Earl Smith M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed R. W. Stoverand

Licensed Embalmer No. 4007

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.